The President's Address before the American Hospital Superintendents' Association

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THE PRESIDENT'S ADDRESS BEFORE THE AMERICAN HOSPITAL SUPERINTENDENTS' ASSOCIATION.*

BY GEORGE H. M. ROWE, M.D., BOSTON.

THE increase in the membership of this association has been so rapid during the last two or three years that I doubt if the majority of those present know our early beginnings. Six years ago, at Cleveland, Ohio, this body was organized, with only eight members, and to them is due the formation of this association.

The second annual conference was held at Pittsburg, 1900, but, judging from the scanty records, the principal business was feasting and excursions.

The third gathering was held in New York, 1901, with forty-four in attendance; and the fourth in Philadelphia, 1902, having as president, Dr. J. T. Duryea, Medical Superintendent of the Brooklyn Borough Hospital. This conference got more strictly down to the business, worthy of those intrusted with interests so important to the well-being of the country.

The fifth annual conference took place at Cincinnati, October, 1903. Fifty-nine members were present and increased interest was shown, on subjects germane and vital. Mr. John Fehrenbatch, Superintendent of the Cincinnati Hospital, was president.

As many of you know, the sixth and last conference was held at Atlantic City, September,

* Held at Boston, Tuesday, Sept. 26.

1904. Sixty-nine members were recorded and a few others failed to register and, therefore, cannot be counted. Mr. Daniel D. Test, Superintendent of the Pennsylvania Hospital, was president. This conference was very successful. Many of the papers were valuable and the discussions proved stimulating. Last year closed with 130 members on the list. It is a pleasure to say that the Membership Committee has been quite successful in its vigorous crusade and our number has received 88 additions during the year, making a total of 218 active members, and we have, also, 9 honorary members.

But let it not be forgotten that there are 1,500 beneficiary hospitals in the United States, not counting insane hospitals, sanatoriums, or private hospitals. There are, therefore, something like 1,300 more superintendents somewhere, that should be gathered into this fold. When every member loyally becomes active propaganda, this association will be a body of intelligent workers, shoulder to shoulder, from the rock-bound shores of Maine to the orange groves of California. Make it known, that the spirit of the association is democratic, inclusive, cooperative, and not organized upon narrow or partisan lines.

Despite the inevitable disappointments from unforeseen but quite reasonable causes, the executive committee hopes that the program will be found practical and helpful, rich with experience rather than theory, and stirring us to renewed effort and better achievement. We bid you welcome, not only to this conference, but we cordially open our hospitals for your inspection; we beg you to enjoy our time-honored city, with its historic associations and works of art, but best of all, we welcome you to the good fellowship of each other.

Of those who were members at the last conference, I know of only one death among our number.

Dr. George F. Keene, Superintendent of the Rhode Island State Hospital for Insane, died at his home in Howard, R. I., March 13, last, from acute croupous pneumonia, after an illness of six days.

Dr. Keene was an exceptional man, of many parts. As an administrator, as an alienist, as a diagnostician, as a writer and as a physician he stood foremost in his community. As a man he was strong in character, sincere in his beliefs, frank and forcible in the expression of his opinions, true in his friendships, honest and faithful in the performance of his duties.

There are many vital and perplexing questions that confront us hospital workers, and from the many-sided nature of a superintendent's work, they sometimes seem beyond the possibility of solution; but there is also sympathy and encouragement for every worker, in knowing that he is not an isolated unit but a part of a great beneficent movement, world-wide, and in which the United States is taking a leading part. No country is making a greater advance in hospital extension than our own. Some statistics which have come to my notice prove this, and I hope you may find them likewise interesting.

By special permission of the United States Bureau of Commerce and Labor, I am allowed to present them to you, in advance of their publication by the department.

Notwithstanding the United States government has thousands of clerks compiling various statistics from different points of view, it is remarkable that there never has been any reliable hospital statistics published by any governmental department except, possibly, schools for nursing,

in the report of the United States Bureau of Education, and in this nothing later than 1902. Among the recent developments in the Department of Commerce and Labor, is a census bureau, with a division of Vital Statistics, which is again divided into the inquiry on pauperism, insanity, feeble-mindedness and benevolence. Under the sub-division of benevolence, a complete census of all the benevolent institutions in the United States was made. Under this phrase ("benevolent institutions") were included all institutions (except hospitals for the insane) which were not run for private profit and depending more or less on endowments, subsidies from public funds, donations, taxes and the like. Inquiry was made of every county clerk in every State of the Union, so that the ground has been well canvassed.

Hospitals were divided into three groups, — public, private and ecclesiastical. Public hospitals include those supported wholly by public cost, that is, paid for in some way by taxation. Private hospitals are the charitable enterprises that are controlled by private organized corporations and not indirectly under the supervision of the civil authorities. The hospitals controlled and maintained by religious denominations or by church associations are designated as ecclesiastical. The general summary gives 1,493 benevolent institutions, or, in round numbers, 1,500. Total number of patients admitted during 1904, 1,064,512; number of nurses, 21,844; total cost of maintenance of all these institutions, $28,200,-869. Of the total number of institutions, 220 were public, 831 private and 442 ecclesiastical. Please observe that there are only half as many public hospitals as there are ecclesiastical hospitals, and only half as many ecclesiastical hospitals as there are private.

It is worthy of notice that the number of small private hospitals which are purely business ventures, is rapidly on the increase in the United States. One or two surgeons having the reputation of being what the laity call, "great surgeons," organize small hospitals, of twenty beds more or less, to which they bring their patients, instead of sending them to the public hospital where, possibly, they are visiting surgeons. The policy of the trustees of many public hospitals in discouraging many private rooms for paying patients, is a factor in this result. Again, certain hospitals do not, under any circumstances, permit a visiting physician or surgeon to take a professional fee from a patient, and this has fostered the establishment of money-making hospitals.

Personally, I am strongly in favor of a reciprocal arrangement between the hospital staff and the management, whereby the hospital, the patient and the doctor can be mutually benefited, by means of a "square deal" for all concerned.

Private hospitals, as purely money-making ventures, find their climax in some of the cities on the Pacific coast, where they are run with the same competition as any business.

The distribution of the public hospitals in the different states stands in the following order: New York, 194; Pennsylvania, 145; Illinois, 105; Massachusetts, 93; Michigan, 59; and so on. Only one state (Nevada) has no hospital, either public, private or ecclesiastical. New York has the largest number of public hospitals, Pennsylvania is second, Illinois third, Massachusetts fourth and California fifth. In the private or corporation hospitals, New York has 123 private as against 29 public hospitals; Pennsylvania has

112, as against 15; Massachusetts, 68 against 13; and Illinois, 42 against 11. Of the ecclesiastical hospitals, Illinois easily leads with 53, New York, 42, Ohio, 27, Minnesota 25, and Wisconsin 22. Ecclesiastical hospitals are found in every state but three, and one of these, somewhat curiously, is Delaware.

During the year 1904, 1,064,512 patients were admitted for treatment. New York led with 246,500, Pennsylvania second, 124,000; Illinois third, 85,600, and Massachusetts fourth, with 48,500, and so on.

The matter of paying patients in 1903 shows that $12,181,484 were collected, which is about 43% of the cost of maintenance of all the tabulated hospitals. In this, New York had the energy to collect $1,951,000; Illinois second, $1,365,000; Massachusetts third, $973,300; and California fourth, $811,809. The total cost of maintenance was $28,200,869. The ratio of the income tallied with the number of private hospitals already given.

It is also interesting to know the number of patients per 100,000 of the population. The District of Columbia comes first, showing that out of every 100,000, 5,220 received beneficiary treatment; next, New York, 3,166; California, 3,039; Massachusetts, 2,420; and after that, the States of Washington, Colorado, Maryland, New Jersey and Illinois.

Many deductions might be made from these figures: for instance, New York State not only led in the total number of beneficiary institutions, but comes second in the ratio of patients to population. The writer has not the local knowledge necessary for determining why the number of patients per 100,000 should be in the following order: District of Columbia, New York State,

California, Massachusetts, State of Washington, Colorado, Maryland and New Jersey. It also appears, incidentally, that the number of resident medical staff in this total of 1,493 hospitals, is 2,863, or an average of about 2 per hospital, and the number of the visiting staff, 15,914, an average of 10.

Out of these 1,493 institutions, 867 maintain training schools for nurses, showing that 58% of the beneficiary institutions now have training schools. There is some discrepancy between the report of the Bureau of Commerce and that of the Commissioner of Education. The latter reports for the year 1903, 13,252 nurses in training while the Bureau of Commerce records 21,844. Perhaps this difference of over 8,000 may be accounted for by the fact that the Bureau of Vital Statistics made its report two years later, and has done it more thoroughly. The ratio of training schools among the states is much the same as the number of hospitals, — New York 117, Pennsylvania 106, Massachusetts 67, Illinois 61, Ohio 43. Among the smaller number it is interesting to note that Montana, Arkansas and Utah each have 3 training schools; Delaware, Idaho, North Dakota and Wyoming each have 2; while Arizona, Indian Territory, New Mexico, have 1 each; Oklahoma being the only one of the United States that has no training school for nurses.

The foregoing statistics are full of significance to the studious hospital superintendent, because it is the first time that reliable data have been accessible. This study might be still further illuminating by classifying with tables of percentages. For instance, New York stands first in the total number of beneficiary institutions and Massachusetts fourth, and this Common-

wealth also furnishes the largest percentage of institutions to its total population. Does this mean that Massachusetts is growing slipshod and tends to medical pauperism, or that it is developing a humanitarian interest which promptly expresses itself in the concrete terms of benevolent institutions? Bear in mind that hospitals for the insane, health sanatoriums and hospitals maintained strictly as money-making concerns are not included in this inquiry.

The growth of benevolent institutions from year to year is extremely interesting. It shows a tendency and "tendencies are the index-fingers on the guide-posts of civilization." In the fourteen years from 1890 to 1903, the number of institutions has shown a remarkable development of 45 to 60 new hospitals every year; in other words, the number nearly doubled. In 1900 the number jumped to 75, and in 1903 there were 90 new ones, an advance really phenomenal.

Civic pride and local philanthropy have caused a remarkable growth in the United States, of hospitals with 20 to 30 beds. Massachusetts, for instance, which, at the close of the Civil War, had only 11 general and cottage hospitals, to-day has 93 hospitals, of which 13 are public, 68 private and 12 ecclesiastical. In the six small New England states there are now 163 hospitals, which is a six-fold increase in thirty-two years.

What does this somewhat lengthy array of figures mean? Does it not indicate an increased public confidence, so that not only the poor, but the well-to-do. class seek hospital treatment? Does it not mean that hospitals, by able management and greater efficiency, have justified themselves, so that the rich are glad to bequeath large sums for their erection and support? At the close of the Civil War the country woke up to its

lamentable deficiency in hospitals. With returning prosperity came greater wealth for larger enterprises, which, with the advances in medicine and surgery and the need of supplying trained nurses, culminated in hospital extension. Certainly this remarkable increase in the United States is one manifestation of the great social and humanitarian movement, which, planted in the nineteenth century, brings to the twentieth century a splendid fruitage.

Hospitals are effective in decreasing the death-rate, and Florence Nightingale said, "The death-rate of a community is the measure of its civilization."

Among the scores of salient and pressing topics, may I bring forward one or two propositions for your consideration?

The annual deficit is a vital question that confronts many hospitals, both large and small, particularly the former. It is occasionally tided over for a single year by a lump sum from a millionaire's purse, but the same causes go on perpetually, and the deficit recurs as surely as the leaves fall in the autumn.

Let us first consider large hospitals in cities. Most of them are built upon restricted sites. To enlarge laterally is to shut out the sun, one of the best of all curative agents. The alternative is to go upwards and some of our hospitals mount to five, eight and even ten stories. The quality of the internal and external construction must keep pace with established standards and the results are, buildings expensive at the outset and costly to maintain.

I would strongly advocate that if large hospitals in cities must increase the bed capacity, it should be done by establishing branch hospitals somewhere outside the crowded city, but easy of

access. This is no new idea. It is probably true that of the patients who have been in the hospital seven days, from 30% to 50% might be transferred to the out-of-town hospital, without detriment, leaving their beds for others requiring immediate or more careful treatment.

Such a branch hospital, on a judiciously selected site, with buildings simple in construction inside and out, would not require the expensive interiors, usually given to operating rooms, administration buildings and other accessories. It could be built for two thirds the amount of money displayed in many of our first-class hospital buildings in cities. The weekly *per capita* cost could be markedly reduced by economies hardly possible in city buildings dependent upon city prices for regular disbursements for maintenance. Such a hospital would supply more sunlight, purer air, and surroundings that conduce to recovery. This branch hospital should be more than a convalescent home, as that term is usually understood, and should be equipped for the continued treatment of acute disease and surgical needs. For instance, the Massachusetts General Hospital has a convalescent home at Waverley, for about thirty-five patients. At first it was only used for convalescents, but later, when applicants were refused at the hospital for want of beds, the experiment was tried of transferring so-called acute cases to the Convalescent Home, to make room at the hospital. Under this procedure, compound fractures, surgical diseases not requiring larger surgical operations, medical cases capable of transfer without injury, were treated there, making it really an annex, or branch hospital. In the last published annual report of the Massachusetts General Hospital, the cost per week in 1904 was $16.95. The average cost per week at

the Convalescent Home was $7.88. Assuming that the patients averaged 35, the difference between supporting only 35 patients at the general hospital and the branch hospital would be about $16,500 per year.

This idea might be developed indefinitely, a hospital being thus composed of two constituents, one in town for emergencies and first care, the other in the country, for the better treatment of a part of the general cases. The obstacles to this scheme would be, primarily, the want of funds, the courage necessary to begin such a project, and probably the opposition of the medical board, as removing useful material for the clinical teaching of medical students.

I desire, however, to stand for this plan as a feasible, economical and rational way of enlarging hospitals in cities. It is one way whereby the weekly *per capita* cost can be radically reduced, as already demonstrated, and it would certainly help to reduce the larger expenditure if not eliminate the notorious annual deficit.

A deficit in the smaller hospitals is even more appalling, since the possible revenues are so limited. Is there a more heroic, not to say pathetic spectacle, than the self-sacrificing and indefatigable struggle of a small band of men and women (especially the women) in their attempt to carry on a cottage hospital of ten or fifteen beds, in a rural community? One possible solution is the long-established custom in Great Britain of having a community hospital, that is, a union of several towns with one hospital at a central point, each town sharing the expense.

The personal element in hospital work is not small. The daily routine with its wearisome details tends to blight originality, alertness, mo-

tive and enthusiasm. Nothing is so deadly as getting into a rut. Who does not need inspiration and new ideas from his hospital neighbor? The flint gives no spark without steel. Let me ask the members present: Do you have a good, cordial acquaintance with every hospital superintendent in your vicinity? How often do you spend two or three hours in visiting your hospital neighbor, with the intent of learning how it is conducted? Why should there not be a national organization that would be an association of hospital managers, by which I mean, managing boards, the superintendents, the auxiliary visiting committees, and perhaps the medical staff also?

Co-operation is the key-note of the era. This is seen in business, railroads, commerce, professions, trades, and that tremendously growing body, — labor unions. Such a combination might not be possible, but the co-operation of hospital communities, with the right spirit and push, need not be difficult.

Take any one of our dozen largest cities. How many hospitals adopt similar methods, as the result of their combined experience? Each has its own arrangement of buildings, the architecture and plans of its wards, different systems of organization, different ways of selecting its ward patients, still greater confusion existing in the appalling out-patient abuse. No two have the same method of bookkeeping; each thinks its own quite as good if not better than its neighbor's. There is no uniformity in the relations and traditions of the medical board to the management, or in the long list of obvious problems that try our souls.

A hospital organization in any community only requires a few leading spirits of the right admixture and happily connected as to institutions.

London has an organiaztion called the Hospital Association. The numerous problems discussed there should bring forth some fruit, but only limited accounts have reached us on this side of the water in regard to results.

The attempt is being made in New York to form a merger called the "New York Association for Improvement of the Condition of the Poor." To be sure, at its first meeting it considered "hospital needs and hospital finances." The association has received copious advice from the lay and the medical press, and our New York coterie of members may perhaps tell us what it has actually accomplished. The primary purpose in this movement was for the poor, the hospital question being a side issue.

In Massachusetts this co-operation has gained some strength in an association of hospital superintendents called the "Hospital Round Table," which meets three or four times each year. Beginning with only half a dozen, it now numbers thirty-six, with an average attendance of twenty-four, and includes the men superintendents of general, special and insane hospitals. The Round Table devotes itself entirely to the discussion of administration problems, and by the freest and most open exchange of experience has furnished valuable information, given fresh courage and promoted good-fellowship.

Following the custom of the men, the women superintendents of nurses have for several years had their "Linda Richards' Club," and, no doubt, have received a similar benefit.

These are good beginnings for something larger and more fruitful, but they have not attained to that dignity or power for hospital workers which I wish to advocate.

May I ask the members of this association to

accept this as a fixed idea? Use every opportunity, encourage every small beginning to foster this plan, with the expectation that in due time some organization may find the place befitting it in the hospital world.

A backward glance is often profitable, but, proud as we rightfully are of the strides made by hospitals in the past twenty-five years, let us not forget that "the only value of a past is to get a better future out of it."

The trend to-day is to make the hospital more and more a great teacher.

Not forgetting that the chief function of a hospital is healing the sick, it is emphatically also the maker of doctors. It has already become an essential, indispensable part of a medical education. Formerly the instruction in the lecture room of the medical school was followed by perfunctory and haphazard walks through a hospital ward. Scores of students sauntered along between rows of beds and listened, at an almost out-of-ear-shot distance, about G—14 or P—23. A student rarely touched a patient, seldom listened to the physical signs, and never really studied a ward case. The surgical operations in the amphitheater could only be vaguely and unseeingly seen, but, thanks to the impulse given by the dominating idea of scientific investigation, all this is being changed. The best system now divides students into small groups, say of eight or ten each. Every student is forced to work out some phase of a specified disease. He sees the patient, he touches the patient, he comes in close personal conduct with the disease of the patient, and begins to get a grip on its meaning. When each student has struggled with his part, separately, they come together to study the patient's disease as a whole.

No practitioner gets experience save by contact. As Dr. Osler has somewhere said, "The whole art of medicine is in observation, but to educate the eye to see, the ear to hear, and the finger to feel takes time, and to start a man in the right direction is all that we can do." From another viewpoint, Dr. John S. Billings has well said, "Teaching hospitals are those where the patient is best observed, best cared for, and receives the greatest benefit." So it has come about in the evolution of medical instruction, that the arena of teaching has been transferred from the lecture room to the hospital wards. The hospital is the real school of the medical student. We must give him the vantage ground of the out-patients, for regular months of observation, manual dexterity, and allow him many hours at the ward bedside, seeing, hearing, questioning, recording, analyzing, as a basis for conclusions.

Then, too, he must have hours of laboratory work upon the pathology of the case, and this also the hospital must supply. Dr. Osler affirms that "for the student of medicine and surgery it is a safe rule to have no teaching without a patient for a text, and the best teaching is that taught by the patient himself."

But, perchance, some of you are opposed to this idea and dislike having students in your wards. Let us not forget that the very word hospital is, fundamentally, hospitality. For us to be inhospitable to new ideas is a sin past forgiveness. Progress is always interrelated and advance follows all along the line. Naturally, a progress in the training of nurses has taken place. The nurses of to-day go out from our hospitals not only enriched with large technical experience, but they have gone below the surface, they "know the reason why." And in this way,

capable, self-sacrificing women are developed into highly intelligent, well equipped nurses.

Nor is this all. The hospital, large or small, not only educates doctors, trains nurses and promotes science, but it sets standards for the countless many who, for the first time in their lives, have a chance to see the value of cleanliness, the importance of details and the beauty of a well-ordered, self-contained life.

My friends, the world has intrusted us with a torch of our own, and whether it is a tiny taper in the window or a flaming beacon on the hill top, we can never know how far it throws its light, or who is being guided by it. Certainly, the best that we can do (and, indeed, it is the *least* that we *should* do) is to make *sure* that our torch is kept steady and burns clear.